

1639 CERTIFICATE OF DEATH

Reg. Dist. No. 56

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, WESTMINSTER				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, WESTMINSTER, MD X2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FINKSBURG, MD. RD				d. STREET ADDRESS FINKSBURG			
3. NAME OF DECEASED (Type or print) First Middle Last LILLIAN GERTRUDE ARMACOST				4. DATE OF DEATH Month Day Year FEB. 9 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 JAN 1872	9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house-wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE CO. MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Wm A. Constantine			
14. MOTHER'S MAIDEN NAME Zenobia Parrish				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic, Hypertensive Cardiovascular Disease DUE TO (c) arterys-							INTERVAL BETWEEN ONSET AND DEATH 10 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 10/31 , 19 53 , to 2/9 , 19 57 , that I last saw the deceased alive on 2/9 , 19 57 , and that death occurred at 11:20 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Allen Moulton				ADDRESS (Street, city or town, state) 148 N. MAIN ST - Westminster, Md.			
PHYSICIAN'S NAME (Type) G. ALLEN MOULTON, M.D.				DATE SIGNED 2/10/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/12/57		22c. NAME OF CEMETERY OR CREMATORY FINKSBURG, CEMETERY		22d. LOCATION (City, town, or county) (State) FINKSBURG, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Murre, Jr.				ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR DATE 2-11-57	
24b. REGISTRAR'S SIGNATURE H. C. Murre							

BUREAU V. 5

1957 13 6

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01647

1640

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, Dykesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, Dykesville x1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>Walter</i> Middle <i>Martin</i> Last <i>Arrington</i>		4. DATE OF DEATH Month <i>Feb</i> Day <i>15</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 21, 1871</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Building</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Austin Arrington</i>		14. MOTHER'S MAIDEN NAME <i>Caroline Hirsch</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-14-0006</i>	
17. INFORMANT Address <i>Mrs. Daisy Arrington - Dykesville, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Sclerosis</i> 345x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1922</i> to <i>2/15/1957</i> , that I last saw the deceased alive on <i>2/14/1957</i> , and that death occurred at <i>9:50 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wm. E. Martin</i> M.D.		ADDRESS (Street, city or town, state) <i>Randallstown</i> DATE SIGNED <i>2/16/57</i>	
PHYSICIAN'S NAME (Type) <i>Wm. E. Martin</i>		<i>RANDALLSTOWN, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-17-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Liberty Freedom</i>	22d. LOCATION (City, town, or county) (State) <i>Edenburg, Carroll, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur N. Wright - Dykesville, Md.</i> ADDRESS		24a. REC'D BY REGISTRAR DATE <i>2-16-57</i>	24b. REGISTRAR'S SIGNATURE <i>C. Harry Weir</i>

RECEIVED

FEB 19 1957

BUREAU V. S.

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
1634
CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF DECEASED: [illegible]
SIGNATURE OF WITNESS: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF CORONER: [illegible]
SIGNATURE OF JUDGE: [illegible]
SIGNATURE OF CLERK: [illegible]

1641

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Westminster				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R.D.1 (Myers Dist.)				e. STREET ADDRESS Westminster, Md. R.D.1 (Myers Dist.)			
3. NAME OF DECEASED (Type or print) First Bessie Middle Larue Last Bankert				4. DATE OF DEATH Month 2/12/57 Day 19 Year 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/30/1899 (1899)	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months 57 Days 19 Hours 19 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Shoe Factory Employee.			10b. KIND OF BUSINESS OR INDUSTRY Own home & Shoe Factory			11. BIRTHPLACE (State or foreign country) Carroll Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Otto Harmon				
14. MOTHER'S MAIDEN NAME Barbara Ellen Sholl			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.				
16. SOCIAL SECURITY NO. 197-05-9381			17. INFORMANT Leonard P. Bankert Address Leonard P. Bankert, Westminster, Md. R.D.1				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11-25, 1955 , to 2-12, 1957 , that I last saw the deceased alive on 2-12, 1957 , and that death occurred at 8:30 P. M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED Littlestown, Pa. 2-13-57							
ACTUAL SIGNATURE L. R. Potter M.D. L. L. Potter							
PHYSICIAN'S NAME (Type) L. L. Potter							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 2/15/57							
22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery							
22d. LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little ADDRESS Littlestown, Pa.							
24a. REC'D BY REGISTRAR DATE 2-15-57							
24b. REGISTRAR'S SIGNATURE Harriet Muller							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01649

CERTIFICATE OF DEATH

1642

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eldersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eldersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Sykesville P.O.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Re Roy</u> <u>Alphonse</u> <u>Beasman</u>		4. DATE OF DEATH Month Day Year <u>Feb.</u> <u>6</u> <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1902</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Painting</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. H. Beasman</u>		14. MOTHER'S MAIDEN NAME <u>Annie R. Stanfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-16-0396</u>	
17. INFORMANT Address <u>Mrs. Claudia Beasman - Sykesville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General carcinomatosis; primary site unknown.</u> 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>mixed met neoplasm cervical lymph nodes</u> DUE TO (c) <u>6 mos.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8-10 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August</u> , 1956, to <u>6 February</u> , 1957, that I last saw the deceased alive on <u>6 February</u> , 1957, and that death occurred at <u>6:50 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Liberty Road at Eldersburg, Sykesville, Md.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr. M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-9-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Freedom</u>	22d. LOCATION (City, town, or county) (State) <u>Eldersburg, Carroll, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight - Sykesville, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>2-8-57</u>	24b. REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>

CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	

13. Name of informant		14. Address of informant		15. Signature of informant	
16. Name of registrar		17. Address of registrar		18. Signature of registrar	
19. Name of physician		20. Address of physician		21. Signature of physician	
22. Name of witness		23. Address of witness		24. Signature of witness	

BUREAU V. S.

FEB 11 1957

RECEIVED

1634

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>126 E. MAIN ST.</u>		d. STREET ADDRESS <u>1 126 E. MAIN ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE LEE BEAVER</u>		4. DATE OF DEATH Month Day Year <u>FEB. 20 1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>WESTMINSTER</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ANDREW J. BEAVER</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH MAGEE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>MRS. JOSEPHINE WEST, WESTMINSTER, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio-sclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>about 6 mo.</u> <u>about 5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Clinically carcinoma of colon (no X-ray or CT to verify)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 1st</u> , 1956, to <u>Feb. 20</u> , 1957, that I last saw the deceased alive on <u>Feb. 19</u> , 1957, and that death occurred at <u>L.F. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. L. Billingslea</u> M.D.		ADDRESS (Street, city or town, state) <u>Westminster, Md.</u> DATE SIGNED <u>Feb. 21, 1957</u>	
PHYSICIAN'S NAME (Type) <u>C. L. Billingslea</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>FEB. 23, 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY WESTMINSTER MD.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster, Md.</u> ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>2-21-57</u>	24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is divided into several horizontal sections with labels for each field.

CHIEF CLERK

BUREAU V. S.

FEB 25 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hale Nursing Home		d. STREET ADDRESS 75X-3	
3. NAME OF DECEASED (Type or print) First Anna Middle Loretta Last Bishop		4. DATE OF DEATH Month Feb. Day 2 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1884 July 9, 1872
9. AGE (In years last birthday) 72 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Glacken		14. MOTHER'S MAIDEN NAME Sarah wolf	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Jacob Bishop		Address Manchester, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocarditis Chronic Decompens 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension DUE TO (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour 0. 21. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-16-57 to 2-2-57 , that I last saw the deceased alive on 2-2-57 19 57 , and that death occurred at 6 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James G. Saffell		ADDRESS (Street, city or town, state) Reisterstown, Md.	
PHYSICIAN'S NAME (Type) James G. Saffell		DATE SIGNED Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 5, 1957	
22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Emmitsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.E. Myers Jr.		ADDRESS Westminster, Md.	
24a. REC'D BY REGISTRAR 2-4-57		24b. REGISTRAR'S SIGNATURE Harriet Miller	

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1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1

(continued)

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BUREAU V. S.

6 -EB- 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01652

1644

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BENEDUM ST</u>		d. STREET ADDRESS <u>BENEDUM ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>T.</u> Middle <u>MAY</u> Last <u>BOND</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 14 - 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOLTEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CORNELIUS BOND</u>		14. MOTHER'S MAIDEN NAME <u>HANNAH ENGLAR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>MRS. M. GRIMES, UNION BRIDGE MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - Breast</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 6, 1956</u> , to <u>Feb 16, 1957</u> , that I last saw the deceased alive on <u>2/16/57</u> , and that death occurred at <u>10:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Pegg</u> M.D. <u>Union Bridge Md</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>T. H. WEGG MD</u>		<u>Union Bridge Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>FEB 19 - 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>METHODIST CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>JOHNSVILLE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hatcher & Sons, Union Bridge Md</u>		24a. REC'D BY REGISTRAR <u>Feb 18/57</u> 24b. REGISTRAR'S SIGNATURE <u>Julius J. Repk</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. DATE OF DEATH: [illegible]
10. SIGNATURE OF PHYSICIAN: [illegible]
11. SIGNATURE OF REGISTRAR: [illegible]

BUREAU V. B.

FEB 20 1957

RECEIVED

1645

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>3 mos, 29 dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>William</u> Last <u>BOONE</u>		4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 26th. 1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Boone</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Yingling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-6664</u>	
17. INFORMANT <u>Springfield Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Infected embolus</u> DUE TO (c) <u>Acute abscesses of prostate & Parotid gland; organism not determined</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with circulatory disturbance with cerebral arteriosclerosis, with psychotic reaction</u>			
19. INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Minutes</u> <u>Days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 27, 1957</u> , to <u>February 26, 1957</u> , that I last saw the deceased alive on <u>February 26, 1957</u> , and that death occurred at <u>6:55 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u>		ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt, M.D.</u>		DATE SIGNED <u>2/27/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-1-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Haugh's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Ladiesburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Lesinger</u>		24. RECORD BY REGISTRAR <u>1957</u>	
ADDRESS <u>Thermon, Maryland</u>		25. REGISTRAR'S SIGNATURE <u>Harry Kern</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01654

1635

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>70 LIBERTY ST.</u>		d. STREET ADDRESS <u>170 LIBERTY</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>CASE</u> Last <u>CASE</u>		4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 6 - 1878</u>
9. AGE (In years last birthday) yrs. <u>78</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY CASE</u>		14. MOTHER'S MAIDEN NAME <u>MARY BEAVER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-07-4419A</u>	
17. INFORMANT <u>Mrs MARGARET E. CASE</u>		Address <u>70 LIBERTY ST. WESTMINSTER, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis (chr), Nephritis chr</u> <u>434.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>cardiac asthma</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1957</u> , to <u>2-1-57</u> , that I last saw the deceased alive on <u>1-31-57</u> , and that death occurred at <u>11:50 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Wm C. Jernette</u> M.D. <u>103 E Main Westminster Md</u>		22. I certify that I attended the deceased from <u>Jan 1, 1957</u> , to <u>2-1-57</u> , that I last saw the deceased alive on <u>1-31-57</u> , and that death occurred at <u>11:50 P.M.</u> from the causes and on the date stated above.	
PHYSICIAN'S NAME (Type) <u>Wm C. Jernette MD</u>		22. I certify that I attended the deceased from <u>Jan 1, 1957</u> , to <u>2-1-57</u> , that I last saw the deceased alive on <u>1-31-57</u> , and that death occurred at <u>11:50 P.M.</u> from the causes and on the date stated above.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-4-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David G. Bankard</u>		ADDRESS <u>Westminster Md.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Herbert Miller</u>	

1981

U. S. BUREAU

1957 6 FEB

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1645

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Windsor				c. LENGTH OF STAY IN 1b years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EMMA CORDELIA CLARY				4. DATE OF DEATH Month Day Year Feb 25 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 14-1882		9. AGE (In years last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Purdum				14. MOTHER'S MAIDEN NAME Martha Molesworth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Oliver Magin, New Windsor Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1955 to Feb 25 1957 , that I last saw the deceased alive on Feb 25 1957 , and that death occurred at 11:30 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE James T. Marsh M.D.				ADDRESS (Street, city or town, state) Westminster Md		DATE SIGNED 2-27-57	
PHYSICIAN'S NAME (Type) JAMES T. MARSH							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 28-1957		22c. NAME OF CEMETERY OR CREMATORY Prospect		22d. LOCATION (City, town, or county) (State) Mt Airy Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W D Hartzler & Sons ADDRESS New Windsor Md				24a. REC'D BY REGISTRAR March 1957		24b. REGISTRAR'S SIGNATURE Emmi S. Bensch	

STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1647

CERTIFICATE OF DEATH

Reg. Dist. No.

01656
(01656)
74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 23yrs 4mo 23days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Richard Middle Bernard Last CLEARY				4. DATE OF DEATH Month February Day 4 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1885	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James H. Cleary				14. MOTHER'S MAIDEN NAME Anna Measa			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Springfield State Hospital Records - Sykesville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction DUE TO 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Annular Carcinoma of rectal-sigmoid junction. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1-2 hours about one year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 11, 1933 , to February 4, 1957 , that I last saw the deceased alive on February 4, 1957 , and that death occurred at 7:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 2-4-57							
ACTUAL SIGNATURE Martin Gross		PHYSICIAN'S NAME (Type) Martin Gross, M. D. Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/7/57		22c. NAME OF CEMETERY OR CREMATORY CATHEDRAL CEM.		22d. LOCATION (City, town, or county) (State) Balto., City	
23. FUNERAL DIRECTOR'S SIGNATURE WIEDEFELD & SON				24a. REC'D BY REGISTRAR GREENMOUNT AVE & 82ND		24b. REGISTRAR'S SIGNATURE C. Harry Heers	

BUREAU V. S.

FEB 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01657

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Rural--Westminster	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Warfieldsburg		d. STREET ADDRESS 1 Nicodemus Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALLEN Middle ROGER Last CLEGG		4. DATE OF DEATH Month Feb. Day 12, Year 19 57	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1935
9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR Months 21 Days 21 Hours 21 Min.	IF UNDER 24 HRS. Months 21 Days 21 Hours 21 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY general	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME ROGER MILTON CLEGG		14. MOTHER'S MAIDEN NAME Cecil Mauck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-30-3474	
17. INFORMANT Roger M. Clegg, Westminster, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Base of Skull 910.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Int. (c), stating the underlying cause last. DUE TO</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) True fall str. hung him on head.	
20c. TIME OF INJURY Month, Day, Year Hour 3 a.m. 2-12-57 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NEIGHBORS FARM	20f. (City or town) (County) (State) RTE 27 CARROLL MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M.C. Porterfield		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Maurice C. Porterfield, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-15-1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland	
24a. REC'D BY REGISTRAR DATE 2/15/57		24b. REGISTRAR'S SIGNATURE Harriet Miller	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

3 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 1649
 CERTIFICATE OF DEATH

01658

Reg. Dist. No. 88

1. PLACE OF DEATH ^a a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JESSE</u> Middle <u>LEE</u> Last <u>CRAWMER</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 7-1875</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DEPUTY SHERIFF</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>COUNTY SHERIFF</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JESSE CRAWMER</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE CRAWMER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HELEN LITTLE</u> Address <u>NEW WINDSOR RURAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial (chr) Infarct (chr)</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>May</u> , 1950, to <u>Feb 23</u> , 1957, that I last saw the deceased alive on <u>Feb 23</u> , 1957, and that death occurred at <u>7:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. C. Jernette</u>				ADDRESS (Street, city or town, state) <u>103 E Main Westminster MD 2-25-57</u>			
PHYSICIAN'S NAME (Type) <u>Wm Carl Jernette</u>				DATE SIGNED <u>Westminster, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB 26-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LINGANORE</u>		22d. LOCATION (City, town, or county) (State) <u>UNIONVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D D Hartzler & Sons</u>				ADDRESS <u>New Windsor</u>		24a. REC'D BY REGISTRAR DATE <u>24/1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Ernie S. Boush</u>			

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 28 1957

RECEIVED

1650

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Westminster				c. LENGTH OF STAY IN 1b 3 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Kate Wagner Rd.			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) WALTER E CROUSE				4. DATE OF DEATH Month Feb Day 25 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-3-1874		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman (retired)		10b. KIND OF BUSINESS OR INDUSTRY B. & O.R.R.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George E. Crouse				14. MOTHER'S MAIDEN NAME Sarah Molesworth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-07-7269		17. INFORMANT Mrs. Edna E. Crouse,		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) fractured hip DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 2 days 14 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerotic C-V disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Tripped and fell				
20c. TIME OF INJURY Month, Day, Year Hour a. m. Feb 11 1957 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Westminster	(County) Carroll	(State) MD		
21. I certify that I attended the deceased from Feb 11 , 19 57 , to Feb 25 , 19 57 , that I last saw the deceased alive on Feb 25 , 19 57 , and that death occurred at 8:05 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James J. Marsh				ADDRESS (Street, city or town, state) Westminster Md		DATE SIGNED 2-26-57	
PHYSICIAN'S NAME (Type) JAMES T. MARSH							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-1-1957	22c. NAME OF CEMETERY OR CREMATORY Pine Grove		22d. LOCATION (City, town, or county) Mt. Airy, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR Feb 28 1957	24b. REGISTRAR'S SIGNATURE Harriet Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01660

1651

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>1yr, 8mos, 28dy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>101 Virginia Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Ernest</u> Last <u>Dodson</u>		4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>19 57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 9, 1868</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hairdresser</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beauty shoppe</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Ernest</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>Unk</u>	
17. INFORMANT <u>Springfield Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 27, 1955</u> to <u>February 25, 1957</u> , that I last saw the deceased alive on <u>February 25, 1957</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.		ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>2/25/57</u>	
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt, M.D.</u>		<u>Sykesville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/27/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber, Laytonville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 2-28-57</u>	
24b. REGISTRAR'S SIGNATURE <u>C. Harry Wilson</u>			

BUREAU V. S.

MAR 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1652

CERTIFICATE OF DEATH

01661

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Finksburg		c. LENGTH OF STAY IN 1b 4 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) RT 1 Finksburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY First Elizabeth Middle Edmonston Last		4. DATE OF DEATH Feb Month 10 Day 1957 Year	
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 17 - 1870 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Robert Francis Warner		14. MOTHER'S MAIDEN NAME Mellisa Jane Potter.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. None	
17. INFORMANT Owen Edmonston Address Finksburg RT 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO Generalized Arteriosclerosis. (c) —			INTERVAL BETWEEN ONSET AND DEATH 7 days. 4 years. years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/20 , 19 56 to 2/10 , 19 57 , that I last saw the deceased alive on 2/9 , 19 57 , and that death occurred at 1:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 148 W Main St Westminster, Md. DATE SIGNED 2/11/57 ACTUAL SIGNATURE G. Allen Moulton M.D. G. ALLEN MOULTON, M.D. PHYSICIAN'S NAME (Type) WESTMINSTER, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/12/1957	22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery	22d. LOCATION (City, town, or county) (State) Kent County Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Amracost ADDRESS Ave. 4600 Liberty Hght		24a. REC'D BY REGISTRAR 2/14/57 24b. REGISTRAR'S SIGNATURE Harriet Miller	

CERTIFICATE OF DEATH

MINNESOTA STATE DEPARTMENT OF HEALTH - BALTICORE 10

Exp. 100 100

BUREAU V. 8

1957 14 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pattapscus</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x1 Pattapscus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				d. STREET ADDRESS <u>✓</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLES - W - ELSE ROAD</u>				4. DATE OF DEATH <u>Feb 9</u> 19 <u>57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3 - 1872</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jeremiah Else Road</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Abbott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mrs Herbert Allgier - Hampstead Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic C-V Disease</u> DUE TO (c) <u>2 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>Feb. 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 7</u> , 19 <u>57</u> , and that death occurred at <u>10:00 p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M.C. Porterfield</u>				ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>		DATE SIGNED <u>2-10-57</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u>				Hampstead, Md.		2/10/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-13-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin E. Tipton, Hampstead Md</u>				24a. REC'D BY REGISTRAR <u>Henry H. Bell</u>		24b. REGISTRAR'S SIGNATURE <u>Henry H. Bell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

LAST NAME		FIRST NAME		MIDDLE NAME	
JONES		JOHN		DAVID	
AGE		SEX		RACE	
65		Male		White	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH	
JAN 15 1892		BALTIMORE, MD		BALTIMORE, MD	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
FEB 10 1957		BALTIMORE, MD		BALTIMORE, MD	
HUSBAND'S NAME		WIFE'S NAME		CHILDREN'S NAMES	
JONES, MARY		JONES, SARAH		JONES, ROBERT	
OCCUPATION		EDUCATION		RELIGION	
Retired		High School		Roman Catholic	
CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY	
Heart Disease		Natural		Hypertension, Atherosclerosis	
ICD-9 CODE		ICD-9 CODE		ICD-9 CODE	
540.0		01		01	
DATE OF AUTOPSY		DATE OF EXAMINATION		DATE OF SIGNATURE	
		FEB 10 1957		FEB 10 1957	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
FEB 10 1957		FEB 10 1957		FEB 10 1957	

BUREAU V. S.

FEB 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1636

CERTIFICATE OF DEATH

Reg. Dist. No.

01663

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Westminster, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>30 W. Green St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>KEY</u> Last <u>ESSICK</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 29, 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henry Miller</u>		14. MOTHER'S MAIDEN NAME <u>Susan Elizabeth Whitmore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>260X Diabetes Mellitus</u>	
17. INFORMANT <u>Miss Agnes R. Essick, Westminster</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 42011 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1</u> , 1950, to <u>Feb 7</u> , 1957, that I last saw the deceased alive on <u>Feb 7</u> , 1957, and that death occurred at <u>4:55 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Julius Chepko</u>		ADDRESS (Street, city or town, state) <u>854 W. Green Westminster Md</u>	
PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>		DATE SIGNED <u>7/8/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 11, 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hughes Lutheran Cemetery Keyman, Carroll Co., Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer, Jr., Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 2-8-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Henrik Muller</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF CORONER		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF BURIAL OFFICIAL		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERMENT		21. SIGNATURE OF CREMATION	
22. SIGNATURE OF REINTERMENT		23. SIGNATURE OF REINTERMENT		24. SIGNATURE OF REINTERMENT	
25. SIGNATURE OF REINTERMENT		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT	
34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT	
40. SIGNATURE OF REINTERMENT		41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT	
43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
46. SIGNATURE OF REINTERMENT		47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT	
49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT	
52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT	
55. SIGNATURE OF REINTERMENT		56. SIGNATURE OF REINTERMENT		57. SIGNATURE OF REINTERMENT	
58. SIGNATURE OF REINTERMENT		59. SIGNATURE OF REINTERMENT		60. SIGNATURE OF REINTERMENT	
61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT	
64. SIGNATURE OF REINTERMENT		65. SIGNATURE OF REINTERMENT		66. SIGNATURE OF REINTERMENT	
67. SIGNATURE OF REINTERMENT		68. SIGNATURE OF REINTERMENT		69. SIGNATURE OF REINTERMENT	
70. SIGNATURE OF REINTERMENT		71. SIGNATURE OF REINTERMENT		72. SIGNATURE OF REINTERMENT	
73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT	
76. SIGNATURE OF REINTERMENT		77. SIGNATURE OF REINTERMENT		78. SIGNATURE OF REINTERMENT	
79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT		81. SIGNATURE OF REINTERMENT	
82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT	
85. SIGNATURE OF REINTERMENT		86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT	
88. SIGNATURE OF REINTERMENT		89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT	
94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT	
100. SIGNATURE OF REINTERMENT		101. SIGNATURE OF REINTERMENT		102. SIGNATURE OF REINTERMENT	

RECEIVED
FEB 13 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1654

CERTIFICATE OF DEATH

01664

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 29 3 Vol-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 436 Rosecroft Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Katherine Middle Garland Last FOX		4. DATE OF DEATH Month February Day 7, Year 1957.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident, right side DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 331x (b) 002x (c)			INTERVAL BETWEEN ONSET AND DEATH Weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. disturbance, with cerebral arteriosclerosis, with psychotic reaction, plus pulmonary tuberculosis.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 12, 1954 , to February 7, 1957 , that I last saw the deceased alive on February 7, 1957 , and that death occurred at 12:Midn , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 2/8/57			
ACTUAL SIGNATURE Walther H. Sonnenfeldt		PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/12/57	
22c. NAME OF CEMETERY OR CREMATORY Wough Chapel Cem		22d. LOCATION (City, town, or county) (State) Balto. Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE George A. Kieber Jr		24a. REC'D BY REGISTRAR DATE FEB 13 1957	
24b. REGISTRAR'S SIGNATURE C. Harry Myers			

CERTIFICATE OF DEATH

1957

PLACE IN SPACE		MARRIAGE	
A. STATE OF MARYLAND		B. COUNTY OF BALTIMORE	
C. CITY OF BALTIMORE		D. DISTRICT OF BALTIMORE	
E. PLACE OF BIRTH		F. PLACE OF DEATH	
G. DATE OF BIRTH		H. DATE OF DEATH	
I. SEX		J. RACE	
K. OCCUPATION		L. CAUSE OF DEATH	
M. MANNER OF DEATH		N. PLACE OF INTERMENT	
O. SIGNATURE OF DECEASED		P. SIGNATURE OF WITNESS	
Q. SIGNATURE OF PHYSICIAN		R. SIGNATURE OF CLERK	
S. SIGNATURE OF MINISTER		T. SIGNATURE OF JUDGE	
U. SIGNATURE OF SHERIFF		V. SIGNATURE OF CORONER	
W. SIGNATURE OF DISTRICT ATTORNEY		X. SIGNATURE OF COUNTY CLERK	
Y. SIGNATURE OF STATE CLERK		Z. SIGNATURE OF BALTIMORE CLERK	

BUREAU V. 3

FEB 13 1957

RECEIVED

THIS CERTIFICATE IS REQUIRED BY THE MARYLAND STATE DEPARTMENT OF HEALTH TO BE FILED IN THE BALTIMORE CITY RECORDS. IT IS THE DUTY OF THE CLERK OF THE BALTIMORE CITY RECORDS TO SEE THAT THIS CERTIFICATE IS FILED IN THE APPROPRIATE RECORDS. THE CLERK OF THE BALTIMORE CITY RECORDS IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE.

Item 20 Film 211 2-25-57 ams

CERTIFICATE OF DEATH

01665

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1yr, 6mo, 16dy			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 3614 839 Bradhurst Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mathilda Middle Margaret Last FRANKENBERG				4. DATE OF DEATH Month February Day 5 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 10, 1864		9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael M. Nachbar				14. MOTHER'S MAIDEN NAME Susan M. Tilghman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unk		17. INFORMANT Address Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 904.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of hip DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 days 14 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome assoc. with disturbance of metabolism, growth or nutrition with senile brain disease with psychotic reaction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient was inadvertently pushed to the floor by another patient					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 1/22/57		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Md.	
21. I certify that I attended the deceased from July 19, 1955 , to February 5, 1957 , that I last saw the deceased alive on February 5, 1957 , and that death occurred at 1:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt				ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 2/5/57			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/8/57		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Bald Md	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck ADDRESS 5305 Harford Rd				24a. REC'D BY REGISTRAR DATE 2-5-57		24b. REGISTRAR'S SIGNATURE C. Henry Allen	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 7 1957

RECEIVED

1637

CERTIFICATE OF DEATH

01666

Reg. Dist. No. 26

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 169 E. Green St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Guy Middle Norman Last Fringer, Sr.				4. DATE OF DEATH Month February Day 18 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1873	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) rt Lynotype Operator			10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME George N. Fringer				14. MOTHER'S MAIDEN NAME Catherine D. Hoff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-01-9281		17. INFORMANT Guy N. Fringer, Jr. Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Renal Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis (Genl) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb 12 , 19 57 , to Feb 18 , 19 57 , that I last saw the deceased alive on Feb 18 , 19 57 , and that death occurred at Nine PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. G. Speicher				ADDRESS (Street, city or town, state) Westminster Md			
PHYSICIAN'S NAME (Type) W. G. Speicher, M.D.				DATE SIGNED 2/19/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-21-57		22c. NAME OF CEMETERY OR CREMATORY Westminster		22d. LOCATION (City, town, or county) (State) Westminster, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers Westminster, Md.				24a. REC'D BY REGISTRAR DATE 2-20-57		24b. REGISTRAR'S SIGNATURE Harriet Miller	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO.

DATE OF DEATH

PLACE OF DEATH

MARRIAGE

DECEASED

DATE OF BIRTH

SEX

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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BUREAU V. R.

FEB 25 1957

RECEIVED

1633

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL CO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			
c. LENGTH OF STAY IN 1b <u>20 YRS</u>				d. STREET ADDRESS <u>138 E-MAIN ST.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>138 E-MAIN ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN BYRON GARTRELL</u>				4. DATE OF DEATH Month Day Year <u>FEB. 26 1957</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 21 1883</u>	9. AGE (In years last birthday) <u>72 yrs.</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CARROLL CO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>STEPHEN F. GARTRELL</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA W. LEATHERWOOD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>				16. SOCIAL SECURITY NO. <u>?</u>			
17. INFORMANT <u>MRS. HOLLOS F. GARTRELL</u>				Address <u>WESTMINSTER, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery disease</u> DUE TO (c) <u>arterio-sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>Probably 2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>8-1</u> , 19 <u>56</u> , to <u>2-26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-25</u> , 19 <u>57</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Westminster, Md.</u>						DATE SIGNED <u>2-27-57</u>	
ACTUAL SIGNATURE <u>C. W. Billingslea</u> M.D.				PHYSICIAN'S NAME (Type) <u>C. W. Billingslea</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr.</u> ADDRESS <u>Westminster, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 2-28-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

MAR

100

[illegible]

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BUREAU V. S.

MAR 4 1957

RECEIVED

1656

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carrollton				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bethel Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Raymond Middle Franklin Last Green				4. DATE OF DEATH Month February Day 13 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1897	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 59	IF UNDER 24 HRS. Days 59 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME David Franklin Green				14. MOTHER'S MAIDEN NAME Edith Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-01-4606		17. INFORMANT Miss Stella Green Finksburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 3221 (b) arteriosclerosis DUE TO (c) Chronic alcoholism						INTERVAL BETWEEN ONSET AND DEATH 2 days 3	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic alcoholism						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb 11 , 19 57 , to Feb 13 , 19 57 , that I last saw the deceased alive on Feb. 12 , 19 57 , and that death occurred at 6:50 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE E. Reese Wilkens M.D.				ADDRESS (Street, city or town, state) 15 Kemper Ave. Westminster, Md.			
PHYSICIAN'S NAME (Type) E. Reese Wilkens, M. D.				DATE SIGNED 2/14/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-16-57		22c. NAME OF CEMETERY OR CREMATORY Carrollton Church of God Carrollton, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers				ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR DATE 2-16-57	
24b. REGISTRAR'S SIGNATURE H. C. Miller							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

CERTIFICATE OF DEATH

STATE OF NEW YORK

BUREAU V. S.

FEB 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15WE(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

1657 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

016698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Westminster c. LENGTH OF STAY IN 1b life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. #5		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Westminster d. STREET ADDRESS R.F.D. #5 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NELLIE Middle HAINES Last HAINES		4. DATE OF DEATH Month FEB. Day 1, Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. ? 1896
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60	IF UNDER 24 HRS. Days 60 Hours 60 Min. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John L. Haines		14. MOTHER'S MAIDEN NAME Fannie B. Wagner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Fannie B. Haines, Same		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation 9250 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH minute			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Top slipped off straw stool - hurled her			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Top slipped off straw stool - hurled her	
20c. TIME OF INJURY Month, Day, Year 4:00 p. m. 2-1-1957		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home farm		20f. (City or town) (County) (State) Westminster Carroll Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James T. Marsh EXAMINER'S NAME (Type) JAMES T. MARSH		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 2-1-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-5-1957	
22c. NAME OF CEMETERY OR CREMATORY Sams Creek Brethren		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR FEB 5 1957 24b. REGISTRAR'S SIGNATURE James T. Marsh	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1658

CERTIFICATE OF DEATH

Reg. Dist. No.

01670

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton			c. LENGTH OF STAY IN 1b 2,649 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3 Vol-4 Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				d. STREET ADDRESS 2930 Southland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lela Middle Mae Last Hammond				4. DATE OF DEATH Month 2- Day 4- Year 1957			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1926		9. AGE (In years last birthday) 30 yrs.	IF UNDER 1 YEAR Months 4 Days 19 Hours 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hammond				14. MOTHER'S MAIDEN NAME Alice Keno			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 102-20-6682		17. INFORMANT Address Mrs. Alice Hammond - Highpoint N.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral cavitory pulmonary TB 002x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 002x DUE TO (c) 002x DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 4, 1949 , to February 4, 1957 , that I last saw the deceased alive on February 4, 1957 , and that death occurred at 12:30A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE T.F. Vestal		M.D. Henryton, Maryland		ADDRESS (Street, city or town, state) Henryton, Maryland		DATE SIGNED 2-4-57	
PHYSICIAN'S NAME (Type) Dr. Tom F. Vestal, Supt.		HOSPITAL (Type) Henryton State Hospital, Henryton, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2.7.57		22c. NAME OF CEMETERY OR CREMATORY Green Hill Cem.		22d. LOCATION (City, town, or county) (State) Highpoint N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Funeral Home				24. REC'D BY REGISTRAR DATE 2-4-57		24b. REGISTRAR'S SIGNATURE Albert R. Swankhouse	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
MARTIN		38		M		W		1889		MASSACHUSETTS	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH	
100 N. ST.		LABORER		HEART DISEASE		2 WEEKS		FEB 2, 1957		HOSPITAL	
MARITAL STATUS		EDUCATION		RELIGION		SIGNED BY		DATE		PLACE	
MARRIED		8 YEARS		CATHOLIC		J. J. [Signature]		FEB 5, 1957		BOSTON	
PREVIOUS DEATHS		SIGNATURE OF PHYSICIAN		DATE		PLACE		SIGNATURE OF REGISTRAR		DATE	
NONE		[Signature]		FEB 5, 1957		BOSTON		[Signature]		FEB 5, 1957	

BUREAU V. 2

FEB 5 1957

RECEIVED

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 100 N. ST. BOSTON, MASS. 02111
 TELEPHONE: 671-1234

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01671

1659

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland c. LENGTH OF STAY IN 1b 21 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Walkersville (Rural) d. STREET ADDRESS 10X12 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Henry Hape		4. DATE OF DEATH Month Day Year 2 18 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1871
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min. 2 18 1957	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Hape		14. MOTHER'S MAIDEN NAME Margret Keeney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic rheumatic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia DUE TO (c) 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with senile brain disease, with psychosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 29, 1957 , to February 18, 1957 , that I last saw the deceased alive on February 18, 1957 , and that death occurred at 6:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gertrude M. Gross, M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Gertrude M. Gross, M.D.		DATE SIGNED 2-18-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/21/1957	
22c. NAME OF CEMETERY OR CREMATORY Mt Hope		22d. LOCATION (City, town, or county) (State) WOODSBORO Md	
23. FUNERAL DIRECTOR'S SIGNATURE G. G. Barton		ADDRESS Walkersville Md	
24a. REC'D BY REGISTRAR DATE 2-22-1957		24b. REGISTRAR'S SIGNATURE Harry Keeney	

FEB 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01672

1660

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31014	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 3012 Loch Raven Blvd., Balto. 18	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arthur Middle Blain Last IRVIN		4. DATE OF DEATH Month February Day 25 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1890
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House painter		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Irvin		14. MOTHER'S MAIDEN NAME Sarah Ann Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-05-6600	
17. INFORMANT Springfield Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction.			
INTERVAL BETWEEN ONSET AND DEATH Hours Years Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 20, 1956 , to Feb. 25, 1957 , that I last saw the deceased alive on Feb. 25, 1957 , and that death occurred at 9:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustin del Campo</i>		ADDRESS (Street, city or town, state) Springfield Hospital	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		DATE SIGNED 2/25/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/28/57	
22c. NAME OF CEMETERY OR CREMATORY U.S. NATIONAL		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE C.F. Hoffmann		ADDRESS 3218 Hudson St.	
24a. REC'D BY REGISTRAR Feb. 26, 1957		24b. REGISTRAR'S SIGNATURE C. Harry Sharp	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED John Davis		AGE 45		SEX Male		RACE White		DATE OF BIRTH 1910		PLACE OF BIRTH MD	
MARRIAGE Married		DATE OF MARRIAGE 1935		PLACE OF MARRIAGE MD		NAME OF SPOUSE John Davis		DATE OF DEATH 1957		PLACE OF DEATH MD	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		OCCUPATION Teacher		EDUCATION High School		RELIGION Methodist		US CITIZENSHIP Yes	
DECEASED'S RESIDENCE 123 Main St, Baltimore, MD		DECEASED'S OCCUPATION Teacher		DECEASED'S EDUCATION High School		DECEASED'S RELIGION Methodist		DECEASED'S US CITIZENSHIP Yes		DECEASED'S MARRIAGE Married	
DECEASED'S NAME John Davis		DECEASED'S AGE 45		DECEASED'S SEX Male		DECEASED'S RACE White		DECEASED'S DATE OF BIRTH 1910		DECEASED'S PLACE OF BIRTH MD	
DECEASED'S MARRIAGE Married		DECEASED'S DATE OF MARRIAGE 1935		DECEASED'S PLACE OF MARRIAGE MD		DECEASED'S NAME OF SPOUSE John Davis		DECEASED'S DATE OF DEATH 1957		DECEASED'S PLACE OF DEATH MD	
DECEASED'S CAUSE OF DEATH Heart Disease		DECEASED'S MANNER OF DEATH Natural		DECEASED'S OCCUPATION Teacher		DECEASED'S EDUCATION High School		DECEASED'S RELIGION Methodist		DECEASED'S US CITIZENSHIP Yes	
DECEASED'S RESIDENCE 123 Main St, Baltimore, MD		DECEASED'S OCCUPATION Teacher		DECEASED'S EDUCATION High School		DECEASED'S RELIGION Methodist		DECEASED'S US CITIZENSHIP Yes		DECEASED'S MARRIAGE Married	
DECEASED'S NAME John Davis		DECEASED'S AGE 45		DECEASED'S SEX Male		DECEASED'S RACE White		DECEASED'S DATE OF BIRTH 1910		DECEASED'S PLACE OF BIRTH MD	

BUREAU V. 31

18 27 1957

RECEIVED

1661

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>	c. LENGTH OF STAY IN 1b <i>12 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville 03-52-2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hospital</i>		d. STREET ADDRESS <i>12 Hillside Road</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Claude</i> Middle <i>Stewart</i> Last <i>Isaacs</i>		4. DATE OF DEATH Month <i>Febr.</i> Day <i>12</i> Year <i>19 57</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-21-1874</i>
9. AGE (In years last birthday) <i>82 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Interior decorator</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>William Isaacs</i>	
14. MOTHER'S MAIDEN NAME <i>Mary E. Wright</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>219-07-325</i>		17. INFORMANT <i>MRS E. H. IRELAND-12 HILLSIDE RD. ROAD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) <i>unknown</i>		INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Nephrosclerosis C.B.S. ass. with cerebral arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1-31-</i> , 19 <i>57</i> , to <i>2-12-</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>2-11-</i> , 19 <i>57</i> , and that death occurred at <i>12:55</i> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walther H. Sonnenfeldt</i> M.D.		ADDRESS (Street, city or town, state) <i>Springfield State Hospital</i> DATE SIGNED <i>2/12/57</i>	
PHYSICIAN'S NAME (Type) <i>Walther H. Sonnenfeldt</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>2/15/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>MT. VIEW CEM.</i>	22d. LOCATION (City, town, or county) (State) <i>SHACKS CORNER HOWARD CO. MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Eastern Sons, Catonsville 28, Md.</i>		24a. REC'D BY REGISTRAR <i>FEB 18 1957</i>	24b. REGISTRAR'S SIGNATURE <i>C. Harry Sturs</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEB 18 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01674

1662

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TANEYTOWN				c. LENGTH OF STAY IN 1b 12 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9 MILL ST.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RAYMOND GARMAN KEEFER				4. DATE OF DEATH Month Day Year FEB. 13 1957			
5. SEX M.	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-10-1899	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER, WESTMINSTER SHOE.		10b. KIND OF BUSINESS OR INDUSTRY MD.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CALVIN KEEFER				14. MOTHER'S MAIDEN NAME FANNIE OTTO			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N		16. SOCIAL SECURITY NO. 213-05-1388		17. INFORMANT Address BEULAH KEEFER TANEYTOWN, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis (color) Hypertension Ch 434.2 DUE TO Cardiac arrhythmia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May 1945 , to Feb. 13 1957 , that I last saw the deceased alive on 2-12-1957 , and that death occurred at 1045 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W.C. Jennette				ADDRESS (Street, city or town, state) DATE SIGNED 103 E Main Westminster Md. 2-17-57			
PHYSICIAN'S NAME (Type) W.C. Carl Jennette				103 E Main Westminster Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-16-1957		22c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH CEM. P.D.7. WESTMINSTER MD.		22d. LOCATION (City, town, or county) (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE David G. Bankard Westminster, Md.				24a. REC'D BY REGISTRAR DATE 2-17-57		24b. REGISTRAR'S SIGNATURE Harold Miller	

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. BROWN		2. SEX MALE		3. AGE 45		4. DATE OF BIRTH 1912		5. PLACE OF BIRTH NEW YORK	
6. OCCUPATION LABORER		7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE 1935		9. PLACE OF MARRIAGE NEW YORK		10. NAME OF SPOUSE MARY J. BROWN	
11. CAUSE OF DEATH HEART DISEASE		12. PLACE OF DEATH HOME		13. DATE OF DEATH FEB 18 1957		14. TIME OF DEATH 10:30 AM		15. SIGNATURE OF PHYSICIAN J. H. SMITH	
16. SIGNATURE OF REGISTRAR M. J. BROWN		17. SIGNATURE OF WITNESS J. H. SMITH		18. SIGNATURE OF WITNESS M. J. BROWN		19. SIGNATURE OF WITNESS J. H. SMITH		20. SIGNATURE OF WITNESS M. J. BROWN	

RECEIVED
FEB 20 1957
BUREAU V. 1

RECEIVED

BUREAU V. S.

FEB 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01677

1665

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1mo., 27 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elmer Middle Ferguson Last LOGUE				4. DATE OF DEATH Month February Day 1 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 1, 1878	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 7 Days 18 Hours 15 Min.		IF UNDER 24 HRS. Months 7 Days 18 Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Andrew Jackson Logue				14. MOTHER'S MAIDEN NAME Mary Emry Ward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-20-8545			
17. INFORMANT Springfield Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease; C.B.S. asso. with cerebral arterio-sclerosis with psychotic reaction.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Springfield				20g. (County) Carroll		20h. (State) Md.	
21. I certify that I attended the deceased from December 4, 1956 , to February 1, 1957 , that I last saw the deceased alive on February 1, 1957 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt				ADDRESS (Street, city or town, state) Springfield State Hospital			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				DATE SIGNED 2/1/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-4-57		22c. NAME OF CEMETERY OR CREMATORY Deer Park	
22d. LOCATION (City, town, or county) Smallwood, Carroll, Md.				22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John Byer - Westminster, Md.				ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR DATE 2-2-57	
24b. REGISTRAR'S SIGNATURE C. Harry Weaver							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01678

* 1666

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 5mos. 22days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15x22 Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 7104 Exeter Rd., Bethesda			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Josephine Middle Trenholm Last LYMAN				4. DATE OF DEATH Month February Day 8 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1875		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 4 Days 20	IF UNDER 24 HRS. Hours 20 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Trenholm				14. MOTHER'S MAIDEN NAME Mary Burroughs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 744		17. INFORMANT Address Springfield Hospital records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 9347 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. asso. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction. Fracture of pubic bone.							INTERVAL BETWEEN ONSET AND DEATH 7 days.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient found lying on floor.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12/26/ 1956 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Md.	
21. I certify that I attended the deceased from August 16, 1956 , to February 8, 1957 , that I last saw the deceased alive on February 7, 1957 , and that death occurred at 12:25 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt				ADDRESS (Street, city or town, state) Springfield Hospital,		DATE SIGNED 2/8/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/11/57		22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 2-9-57	
						24b. REGISTRAR'S SIGNATURE C. Harry Albee	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01679

1667

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2. UNION BRIDGE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST</u>				d. STREET ADDRESS <u>1 MAIN ST</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>WILLIAM</u> Middle <u>MACKLEY</u> Last				4. DATE OF DEATH Month <u>FEB.</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 21-1977</u>		9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PIPE FITTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>MILTON A MACKLEY</u>				14. MOTHER'S MAIDEN NAME <u>MARY LITTLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-14-7601</u>		17. INFORMANT Address <u>Mrs Fred Eyles, Union Bridge Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-vascular</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>disease.</u> DUE TO (c) <u>1022.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1/21</u> , 19 <u>56</u> , to <u>2/13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/13</u> , 19 <u>57</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. E. Robertson</u>				M.D. <u>New Windsor, Md</u>		DATE SIGNED <u>2/13/57</u>	
PHYSICIAN'S NAME (Type) <u>M E. ROBERTSON</u>				<u>NEW WINDSOR, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB 16-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT VIEW</u>		22d. LOCATION (City, town, or county) (State) <u>UNION BRIDGE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartley & Sons</u> ADDRESS <u>Union Bridge</u>				24a. REC'D BY REGISTRAR DATE <u>2/14/57</u>		24b. REGISTRAR'S SIGNATURE <u>John S. [Signature]</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES EARL RAY		MALE		35		JAN 19 1928		MOBILE, ALABAMA		LABORER		SINGLE		WHITE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
JAN 30 1968		10:00 PM		MEMPHIS, TENNESSEE		HEART DISEASE		SUICIDE		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
17. COUNTY		18. CITY		19. STATE		20. ZIP CODE		21. COUNTY		22. CITY		23. STATE		24. ZIP CODE	
MEMPHIS		MEMPHIS		TENNESSEE		38101		MEMPHIS		MEMPHIS		TENNESSEE		38101	

BUREAU V. S.

FEB 18 1967

RECEIVED

RECEIVED
FEB 18 1967
BUREAU V. S.

1668

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 5yr, 5mo, 1dy			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Florence Middle Margaret Last MAJCHRAK				4. DATE OF DEATH Month February Day 8 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1899	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland-		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Cork			14. MOTHER'S MAIDEN NAME Rose Zaporowska				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	17. INFORMANT Address Springfield Hospital Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant melanoma or thigh, Grade 4 190X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, paranoid type, plus arrested pulmonary tuberculosis.						INTERVAL BETWEEN ONSET AND DEATH Years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from October 20, 1954 , to February 8, 1957 , that I last saw the deceased alive on February 8, 1957 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus		ADDRESS (Street, city or town, state) Springfield Hospital			DATE SIGNED 2/8/57		
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		Sykesville, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 11, 1957	22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus	22d. LOCATION (City, town, or county) (State) Dundalk Ave. Md.				
23. FUNERAL DIRECTOR'S SIGNATURE John J. Nuda		ADDRESS 2829 Hudson St. Baltimore 24 Md.		24a. REC'D BY REGISTRAR DATE 2/14/57	24b. REGISTRAR'S SIGNATURE C. Harry Wees		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1669

CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Westminster	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 417 E. Main St.		d. STREET ADDRESS 1 417 E. Main St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle Martin Last Mancha		4. DATE OF DEATH Month February Day 11 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 1, 1875
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Carpenter		10b. KIND OF BUSINESS OR INDUSTRY House Builder	
11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Lewis Mancha		14. MOTHER'S MAIDEN NAME Louisa Riffle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Edward M. Mancha		Address Westminster, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of intestine - 153x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Met. in liver & lung (R) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 2-10-1957 , to Feb 11-1957 , that I last saw the deceased alive on 2-10-1957 , and that death occurred at 1:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. C. Jennette		ADDRESS (Street, city or town, state) 103 E. Main Westminster Md 2-12-57	
DATE SIGNED 2-12-57			
PHYSICIAN'S NAME (Type) W. C. Jennette, M.D.		103 E. Main St. Westminster, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-14-57	22c. NAME OF CEMETERY OR CREMATORY Westminster	22d. LOCATION (City, town, or county) (State) Westminster, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Md.	
24a. REC'D BY REGISTRAR 2-14-57		24b. REGISTRAR'S SIGNATURE H. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		DISEASE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL		SIGNATURE OF CREMATION		SIGNATURE OF OTHER		SIGNATURE OF OTHER	

BUREAU V. S.

FEB 18 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01682

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
c. LENGTH OF STAY IN 1b <u>74 yr</u>		d. STREET ADDRESS <u>68 1/2 MADISON ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>68 1/2 MADISON ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>A.</u> Last <u>MANCHA</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 13, 1882</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER RET. LUMBER YARD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LOUIS MANCHA</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE RIFFLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-01-1704</u>	
17. INFORMANT <u>Bessie H Mancha</u> Address <u>68 1/2 Madison Westminister md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Prostate</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1956</u> , to <u>Feb 20, 1957</u> , that I last saw the deceased alive on <u>Feb 20, 1957</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Julius Chepko</u> M.D. <u>85 1/2 W Green</u>		DATE SIGNED <u>2/20/57</u>	
PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>		<u>Westminster md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-22-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>David R. Bankard</u> ADDRESS <u>Westminster md</u>		24a. REC'D BY REGISTRAR <u>Harriet Miller</u>	24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>

CERTIFICATE OF DEATH

1957

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]		7. MARITAL STATUS [Faint text]		8. RACE [Faint text]		9. RELIGION [Faint text]		10. EDUCATION [Faint text]		11. SOCIAL SECURITY NUMBER [Faint text]		12. DATE OF DEATH [Faint text]		13. PLACE OF DEATH [Faint text]		14. CAUSE OF DEATH [Faint text]		15. MANNER OF DEATH [Faint text]		16. SIGNATURE OF DECEASED [Faint text]		17. SIGNATURE OF WITNESSES [Faint text]		18. SIGNATURE OF PHYSICIAN [Faint text]		19. SIGNATURE OF CORONER [Faint text]		20. SIGNATURE OF JURY [Faint text]		21. SIGNATURE OF JUDGE [Faint text]		22. SIGNATURE OF CLERK [Faint text]		23. SIGNATURE OF REGISTRAR [Faint text]		24. SIGNATURE OF VENDOR [Faint text]		25. SIGNATURE OF OTHER [Faint text]	
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BUREAU V. 5

FEB 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

016837

1671

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine x 2</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>Day P.O.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Charissa</u> Middle <u>Marshall</u> Last		4. DATE OF DEATH <u>Feb.</u> Month <u>11</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1865</u>
9. AGE (In years last birthday) <u>91</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marion M. Mills</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Gosnell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Alma Harvey - Woodbine, md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardio-vascular disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>general arteriosclerosis</u> DUE TO (c) <u>senile changes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u> <u>30 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1935</u> , 19____, to <u>11 February 1957</u> , that I last saw the deceased alive on <u>11 February</u> , 19 <u>57</u> , and that death occurred at <u>11:05 A.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Liberty Road at Eldersburg</u> DATE SIGNED <u>2-12-57</u>			
ACTUAL SIGNATURE <u>W. H. Lawson, Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr. M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-13-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Sykesville, md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Knight - Sykesville, md.</u>		24a. REC'D BY REGISTRAR <u>2-12-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. Robert [illegible]</u>			

1 15 1 0 1 VS A15 (4) 15M 9/55 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1672

CERTIFICATE OF DEATH

01684

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>3mon, 6 dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Evelyn</u> Last <u>MASON</u>				4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31, 1870</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Receptionist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Job Macomber</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Aldrich</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>135-26-3692</u>		17. INFORMANT Address <u>Springfield Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome assoc. with arteriosclerosis with psychotic reac-</u> <u>tion</u>							INTERVAL BETWEEN ONSET AND DEATH years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>November 8, 19 56</u> , to <u>February 14, 19 57</u> , that I last saw the deceased alive on <u>February 14, 19 57</u> , and that death occurred at <u>10:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>2/15/57</u>			
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt, M.D.</u>				<u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>New Bedford, Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Bumphey</u> ADDRESS <u>8434 Georgia ave. Silver Spring</u>				24a. REC'D BY REGISTRAR <u>DATE 2-18-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>	

1673

CERTIFICATE OF DEATH

Reg. Dist. No.

(01685) 76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 7</u>		d. STREET ADDRESS <u>R7</u>	
3. NAME OF DECEASED (Type or print) <u>CARL</u> First <u>ARTHUR</u> Middle <u>MIELKE</u> Last		4. DATE OF DEATH <u>Feb</u> Month <u>17</u> Day <u>1957</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 23, 1882</u> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August Mielke</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Schauk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Evelyn Gunther Westminster Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S.C.V. disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u> <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1957</u> to <u>Feb 17</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Feb 16</u> , 19 <u>57</u> , and that death occurred at <u>1:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Westminster Md</u> DATE SIGNED <u>2/17/57</u>			
ACTUAL SIGNATURE <u>James J. Marshall</u> M.D.		PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 20 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wards Chapel Cemetery Holbrook, Balto. Co., Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellis Amoreau</u> ADDRESS <u>4310 Liberty Heights Avenue.</u>		24a. REC'D BY REGISTRAR <u>FEB 19 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1073

BUREAU V. S.

FEB 19 1957

RECEIVED

1675

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MANCHESTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Manchester Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u>				d. STREET ADDRESS <u>128 W main st.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Cora</u> First <u>B.</u> Middle <u>Morgan</u> Last		4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>1957</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 30, 1892</u>				
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u> Hours <u>0</u> Min. <u>0</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>					
11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Robert Boyce</u>		14. MOTHER'S MAIDEN NAME <u>Wilhelmina Bonnet</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>					
17. INFORMANT <u>W. Boyce Morgan, 6219 Selkirk Dr. Bethesda Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 420.1 DUE TO (b) <u>Arterio-sclerotic Cardiovascular disease?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>Sept 25</u> , 1954, to <u>February 18</u> , 1957, that I last saw the deceased alive on <u>Feb 18</u> , 1957, and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md</u>					
DATE SIGNED <u>2-18-57</u>		PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-22-1957</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Sharon Pa</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin R. Kipton</u>		ADDRESS <u>Hampstead Md</u>					
24a. REC'D BY REGISTRAR <u>Feb 20/57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. S. Denner</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 25 1957

RECEIVED

167 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7, Film 6223, 11-27-57, E7

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	c. LENGTH OF STAY IN lb 20 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 vol. 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 15 Springfield State Hospital 2		d. STREET ADDRESS 5205 Windsor Mill Road	
3. NAME OF DECEASED (Type or print) First Irene Middle Agnes Last Miller		4. DATE OF DEATH Month Febr. Day 21 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> Married DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/28/1894
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	11. BIRTHPLACE (State or foreign country) USA
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Carroll	
14. MOTHER'S MAIDEN NAME Sally Thomas		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT HOSPITAL RECORDS.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260x DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus - Psychoneurosis - Reactive depression 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James J. Shorck		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES T MARSH		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-26-57	22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL	22d. LOCATION (City, town, or county) (State) BALTIMORE MD
23. FUNERAL DIRECTOR'S SIGNATURE George L. Schwalb		24a. REC'D BY REGISTRAR DATE FEB 25 1957	
		24b. REGISTRAR'S SIGNATURE C. Harry Steers	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

FEB 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01688
80

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keyville			c. LENGTH OF STAY IN 1b life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Keyville					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D. Keymar				d. STREET ADDRESS 1 R.D. Keymar			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOSEPH E. MULLER				4. DATE OF DEATH Month FEB. Day 7, Year 19 57							
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-10-1956		9. AGE (In years last birthday) 7 yrs. 27 Months 27 Days			
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Charles Muller Jr.				14. MOTHER'S MAIDEN NAME Hannah J. Ecker							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ----		17. INFORMANT Charles Muller Jr., R.D. Keymar, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Infection 475X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)								INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE James J. Marsh M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED 2-7-57					
EXAMINER'S NAME (Type) JAMES T MARSH DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					
22b. DATE THEREOF 2-9-1957		22c. NAME OF CEMETERY Salem		22d. LOCATION (City, town, or county) Carroll Co., Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Maryland						24a. REC'D BY REGISTRAR FEB 11 1957		24b. REGISTRAR'S SIGNATURE Eric Benedict			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1000224XY4

BUREAU V. S.

FEB 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01689

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City City					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN lb 2mos.9days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3034 Abell Avenue 3v01-4				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS Baltimore, Maryland.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rita Louise Hild Middle NIELSEN Last				4. DATE OF DEATH Month February Day 19 Year 1957					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Jan. 7, 1914			
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical work			10b. KIND OF BUSINESS OR INDUSTRY Unk		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles Hild				14. MOTHER'S MAIDEN NAME Anna McMann					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Address Springfield Hospital records.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Interstitial and suppurative bronchopneumonia DUE TO (c) 491X							INTERVAL BETWEEN ONSET AND DEATH Instant Days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE James T. Marsh				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) James T. Marsh, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				2/19/57	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
BURIAL		2-22-57		NEW CATHEDRAL		BALTO MD			
23. FUNERAL DIRECTOR'S SIGNATURE William Cook				ADDRESS 1217 ST PAUL ST		24a. REC'D BY REGISTRAR 2-20-57		24b. REGISTRAR'S SIGNATURE C. Henry Talen	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the office of the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
FEB 21 1957
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01690

CERTIFICATE OF DEATH

1678

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		MARYLAND		STATE Maryland		COUNTY ---	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN Rural - Sykesville		since 11/11/49		TOWN Baltimore City			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
Springfield State Hospital				3 Vol-4 1019 S. Bouldin St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Patrick (Middle) - (Last) OATES				(Month) February (Day) 20 (Year) 19 57			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	white	married	November 12, 1871	85 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Gardener		Gardening		Ireland		unknown	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Oates BARTHOLOMEW OATES.				unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		unknown		Records of Springfield State Hospital			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) Coronary Occlusion						1 day	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) Cerebral Vascular Accident						6 months more than 10 years	
(C) Generalized Arteriosclerosis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile Psychosis, simple deterioration.						10 yrs. +	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 26, 1949 , to 2-20 , 19 57 , that I last saw the deceased alive on 2-20 , 19 57 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.							
SIGNATURE Gertrude M. Goss, M.D.				ADDRESS (Street, city, town, state) Sykesville, Maryland		DATE SIGNED 2-20-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		2- -57		HOLY REDEEMER CEM.		4430 BELAIR RD. BALTO, MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 2-21-57		C. Harry Hays		Charles L. Giller		901 S. CONKLING ST. BALTO, MD.	

RECEIVED

RECEIVED
FEB 25 1957
BUREAU V. 2

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE

11. DATE

12. SIGNATURE

13. DATE

14. SIGNATURE

15. DATE

16. SIGNATURE

17. DATE

18. SIGNATURE

19. DATE

20. SIGNATURE

21. DATE

22. SIGNATURE

23. DATE

24. SIGNATURE

25. DATE

26. SIGNATURE

27. DATE

28. SIGNATURE

29. DATE

30. SIGNATURE

31. DATE

32. SIGNATURE

33. DATE

34. SIGNATURE

35. DATE

36. SIGNATURE

37. DATE

38. SIGNATURE

39. DATE

39. SIGNATURE

40. DATE

RECEIVED
FEB 25 1957
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03518

CERTIFICATE OF DEATH

01691

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 9 Whitefield Rd			
3. NAME OF DECEASED (Type or print) First Walter Middle Dawson Last Owens				4. DATE OF DEATH Month 2 Day 1 Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-76		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Comptroller		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry F. Owens				14. MOTHER'S MAIDEN NAME Henrietta Weems			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unkn		16. SOCIAL SECURITY NO. 705-1261542		17. INFORMANT Address Mrs. Mildred P. Owens-9 Whitfield Rd. #10			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 331x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular accident DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 4 months plus years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psych. reactions							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 8, 1957 , to Febr. 1, 1957 , that I last saw the deceased alive on Febr. 1, 1957 , and that death occurred on 6 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 2-2-57							
ACTUAL SIGNATURE Edmund Lusthaus				PHYSICIAN'S NAME (Type) Edmund Lusthaus			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/5/57		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker				24a. REC'D BY REGISTRAR EB 4 1957 24b. REGISTRAR'S SIGNATURE C. Harry Hays			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01692

1679

CERTIFICATE OF DEATH

Reg. Dist. No.

77

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x20 Hampstead - Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>LOUIS-A-PARSONS</u>		4. DATE OF DEATH <u>Feb 10 - 19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9 - 1872</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>Burlington, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albion Parsons</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Hilbary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>920</u>	
17. INFORMANT <u>Mrs Pauline Parsons - Hampstead Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Oedema</u> 422.1 DUE TO (b) <u>Arterio-sclerotic C-V Diseases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> 3-4 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1953</u> to <u>Feb 10 1957</u> , that I last saw the deceased alive on <u>Feb 9 1957</u> , and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Porterfield</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md</u>	
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>		DATE SIGNED <u>2-11-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-13-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. Crpton, Hampstead Md</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>2/11/57</u>		24b. REGISTRAR'S SIGNATURE <u>Henry Lewis</u>	

MEDICAL CERTIFICATION

RECEIVED

FEB 13 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01693

1680

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>			c. LENGTH OF STAY IN 1b <u>17 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Mt. Airy</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>East Church Street</u>				d. STREET ADDRESS <u>1 same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie Elizabeth Poole</u>				4. DATE OF DEATH Month Day Year <u>February 10 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 8, 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles E. Phebus</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Crummitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>—</u>		17. INFORMANT <u>Mrs. Laura Chaney</u>		Address <u>Mt. Airy</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Diabetes mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>4 years</u> <u>more than 6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> to <u>February, 1957</u> , that I last saw the deceased alive on <u>Feb. 9, 1957</u> , and that death occurred at <u>12:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.B. Culwell</u>		M.D. <u>Mt. Airy</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>2/10/57</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>				<u>Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 12, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Airy, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Moleworth</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2-12-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Robert R. Hewitt</u>			

1957 14 3

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2yrs. 4mos. 22days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3001.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 5 N. Exeter St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Martin ROBERTS				4. DATE OF DEATH Month February Day 20 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 8, 1875	
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Christopher Columbus Roberts		14. MOTHER'S MAIDEN NAME -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-intestinal hemorrhage 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Peptic ulcer DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (c) C.B.S. associated with dist. of metabolism, with senile brain disease, with psychotic reaction.				INTERVAL BETWEEN ONSET AND DEATH Days Years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour o. f. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept. 28, 1954 , to Feb. 20, 1957 , that I last saw the deceased alive on February 20, 1957 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus				M.D. Springfield Hospital		DATE SIGNED 2/21/57	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-23-57		22c. NAME OF CEMETERY OR CREMATORY Sonnet		22d. LOCATION (City, town, or county) (State) Shelby N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Palmer - M. Paul - Shelby, N.C.				ADDRESS Shelby, N.C.		24a. REC'D BY REGISTRAR C. Harry	
24b. REGISTRAR'S SIGNATURE C. Harry				DATE Feb 21/57			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

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FEB 25 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

* 1682

CERTIFICATE OF DEATH

01695

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 5yrs. 2mos. 25days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 3V014 4700 Harford Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Henrietta Middle M. Last SCHOTT				4. DATE OF DEATH Month February Day 1 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 26, 1873		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH Days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis, simple deterioration, arteriosclerotic convulsions							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 6, 1951 , to February 1, 1957 , that I last saw the deceased alive on February 1, 1957 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 2/2/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 2-5-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore, Md.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Pittsville				ADDRESS Pittsville		24a. REC'D BY REGISTRAR DATE 2-7-57	
				24b. REGISTRAR'S SIGNATURE C. Harry Sharp			

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(d) _____

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01696

CERTIFICATE OF DEATH

Reg. Dist. No. 11

1683

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Black Rock Road</u>		d. STREET ADDRESS <u>Black Rock Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Groce</u> Middle <u>Ann</u> Last <u>Schultz</u>		4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Robert E. Mumpman</u>	
14. MOTHER'S MAIDEN NAME <u>Rosella K. Cunniff</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>121-10-9895</u>		17. INFORMANT <u>Mrs. Mary Cole</u> Address <u>Hampstead, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion Aorta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cerebrovascular Disease</u> DUE TO <u>12 hours</u> (c) <u>years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> <u>—</u> <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 14</u> , 19 <u>56</u> , to <u>February 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>February 2</u> , 19 <u>57</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		DATE SIGNED <u>3/3/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 6/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Groce Methodist Bldg. Co Md</u>
22d. LOCATION (City, town, or county) (State) <u>Hampstead Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. C. Tipton</u> ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>Henry Jones</u>		24b. REGISTRAR'S SIGNATURE <u>Henry Jones</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Form 100-100

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BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01697

Reg. Dist. No. 76

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Finksburg	c. LENGTH OF STAY IN 1b 9yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Rural--Finksburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gamber		d. STREET ADDRESS Gamber	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle S. Last SHIPLEY		4. DATE OF DEATH Month FEB. Day 19, Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-8-1881
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John R. Paynter		14. MOTHER'S MAIDEN NAME Elizabeth Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Grove M. Shipley, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 Carcinoma of liver DUE TO (b) metastases to lungs DUE TO (c) Cachexia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-1-56 to 2-19-57 , that I last saw the deceased alive on 2-17-57 , and that death occurred at 2 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Reisterstown Md DATE SIGNED 2-19-57 ACTUAL SIGNATURE James E. Saffell M.D. PHYSICIAN'S NAME (Type) James E. Saffell Reisterstown Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-22-1957	22c. NAME OF CEMETERY OR CREMATORY Providence	22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, J		24a. RECEIVED BY REGISTRAR FEB 21 1957	
ADDRESS Winfield, Maryland		24b. REGISTRAR'S SIGNATURE Harriet Muller	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH	
5. PLACE OF DEATH		6. CAUSE OF DEATH		7. MANNER OF DEATH		8. SIGNATURE OF PHYSICIAN	
9. SIGNATURE OF REGISTRAR		10. SIGNATURE OF WITNESS		11. SIGNATURE OF DECEASED		12. SIGNATURE OF SURVIVOR	
13. SIGNATURE OF FUNERAL HOME		14. SIGNATURE OF BURIAL PLACE		15. SIGNATURE OF INTERVIEWER		16. SIGNATURE OF INTERVIEWEE	
17. SIGNATURE OF INTERVIEWER		18. SIGNATURE OF INTERVIEWEE		19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWEE	
21. SIGNATURE OF INTERVIEWER		22. SIGNATURE OF INTERVIEWEE		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWEE	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWEE		27. SIGNATURE OF INTERVIEWER		28. SIGNATURE OF INTERVIEWEE	
29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWEE		31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWEE	
33. SIGNATURE OF INTERVIEWER		34. SIGNATURE OF INTERVIEWEE		35. SIGNATURE OF INTERVIEWER		36. SIGNATURE OF INTERVIEWEE	
37. SIGNATURE OF INTERVIEWER		38. SIGNATURE OF INTERVIEWEE		39. SIGNATURE OF INTERVIEWER		40. SIGNATURE OF INTERVIEWEE	
41. SIGNATURE OF INTERVIEWER		42. SIGNATURE OF INTERVIEWEE		43. SIGNATURE OF INTERVIEWER		44. SIGNATURE OF INTERVIEWEE	
45. SIGNATURE OF INTERVIEWER		46. SIGNATURE OF INTERVIEWEE		47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF INTERVIEWEE	
49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWEE		51. SIGNATURE OF INTERVIEWER		52. SIGNATURE OF INTERVIEWEE	
53. SIGNATURE OF INTERVIEWER		54. SIGNATURE OF INTERVIEWEE		55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF INTERVIEWEE	
57. SIGNATURE OF INTERVIEWER		58. SIGNATURE OF INTERVIEWEE		59. SIGNATURE OF INTERVIEWER		60. SIGNATURE OF INTERVIEWEE	
61. SIGNATURE OF INTERVIEWER		62. SIGNATURE OF INTERVIEWEE		63. SIGNATURE OF INTERVIEWER		64. SIGNATURE OF INTERVIEWEE	
65. SIGNATURE OF INTERVIEWER		66. SIGNATURE OF INTERVIEWEE		67. SIGNATURE OF INTERVIEWER		68. SIGNATURE OF INTERVIEWEE	
69. SIGNATURE OF INTERVIEWER		70. SIGNATURE OF INTERVIEWEE		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF INTERVIEWEE	
73. SIGNATURE OF INTERVIEWER		74. SIGNATURE OF INTERVIEWEE		75. SIGNATURE OF INTERVIEWER		76. SIGNATURE OF INTERVIEWEE	
77. SIGNATURE OF INTERVIEWER		78. SIGNATURE OF INTERVIEWEE		79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF INTERVIEWEE	
81. SIGNATURE OF INTERVIEWER		82. SIGNATURE OF INTERVIEWEE		83. SIGNATURE OF INTERVIEWER		84. SIGNATURE OF INTERVIEWEE	
85. SIGNATURE OF INTERVIEWER		86. SIGNATURE OF INTERVIEWEE		87. SIGNATURE OF INTERVIEWER		88. SIGNATURE OF INTERVIEWEE	
89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWEE		91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWEE	
93. SIGNATURE OF INTERVIEWER		94. SIGNATURE OF INTERVIEWEE		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWEE	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWEE		99. SIGNATURE OF INTERVIEWER		100. SIGNATURE OF INTERVIEWEE	

BUREAU V. S.

FEB 21 1957

RECEIVED

1685 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				d. STREET ADDRESS 2141 W. North Avenue			
3. NAME OF DECEASED (Type or print) First Millie Middle Last Snowden				4. DATE OF DEATH Month February Day 19 Year 1957			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-11-1877	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Frederick, Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Richardson				14. MOTHER'S MAIDEN NAME Kate Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Millie Snowden - Patient			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Far adv. bilateral pulm. TB with cavitation (c) Far adv. bilateral pulm. TB with cavitation						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 27, 1955 , to Feb. 19, 1957 , that I last saw the deceased alive on Feb. 19, 1957 , and that death occurred at 12:35 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE T.F. Vestal M.D.				ADDRESS (Street, city or town, state) Henryton, Maryland			
DATE SIGNED 2-20-57							
PHYSICIAN'S NAME (Type) Dr. Tom F. Vestal, Supt.				Henryton State Hospital, Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-23-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William A. Jackson Funeral Home Inc.				24a. REC'D BY REGISTRAR DATE 2-20-57		24b. REGISTRAR'S SIGNATURE Albert R. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1686

CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Westminster				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R. D. 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Maggie Middle J. Last Sternor				4. DATE OF DEATH Month 2/8/57 Day 19 Year 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/24/1879	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.	IF UNDER 24 HRS. Months 77 Days 77 Hours 77 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework, Housewife, Retired, Own home.				10b. KIND OF BUSINESS OR INDUSTRY Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Leese				14. MOTHER'S MAIDEN NAME Leah Brillhart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Chester Petry Address Westminster, Md. R.D.1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X DUE TO Common subacute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 153X DUE TO (c) 153X							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1950 to 2-8-57 , 19 57 , that I last saw the deceased alive on 2-7-57 , 19 57 , and that death occurred at 10:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. C. Jernette M.D.				DATE SIGNED 2-8-57			
PHYSICIAN'S NAME (Type) Wm. Carl Jernette M.D. Westminster Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/11/57		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little				ADDRESS Littlestown, Pa.		24a. REC'D BY REGISTRAR 2-8-57	
				24b. REGISTRAR'S SIGNATURE Harriet Miller			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1637
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01700

CERTIFICATE OF DEATH

Items 14, 8, 9: G 210 2-7-57L

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>since 8-1-56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marie Estella Waters</u>				4. DATE OF DEATH Month Day Year <u>2 (second) 19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-19 80</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA (naturalized)</u>
13. FATHER'S NAME <u>John Bilek</u>				14. MOTHER'S MAIDEN NAME <u>Anna Kavarish KARAS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unkn</u>		16. SOCIAL SECURITY NO. <u>unkn</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> <u>443X</u> INDEX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebrovascular accident</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>6 months</u>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chron. brain syndr. assoc. with cerebral arterioscler. with psych. react.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 1, 1956</u> , to <u>Febr. 1, 1957</u> , that I last saw the deceased alive on <u>2-1-1957</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>2-2-57</u>							
ACTUAL SIGNATURE <u>Edmund Lusthaus</u>				PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street.</u>				24a. REC'D BY REGISTRAR DATE <u>2-2-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Edelen</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. PLACE OF DEATH</p>	
<p>7. OCCUPATION</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MANNER OF DEATH</p>		<p>10. TIME OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. DATE OF DEATH</p>		<p>14. PLACE OF INTERMENT</p>	
<p>15. NAME OF CEMETERY</p>		<p>16. NAME OF FUNERAL HOME</p>	
<p>17. NAME OF FUNERAL HOME</p>		<p>18. NAME OF FUNERAL HOME</p>	
<p>19. NAME OF FUNERAL HOME</p>		<p>20. NAME OF FUNERAL HOME</p>	
<p>21. NAME OF FUNERAL HOME</p>		<p>22. NAME OF FUNERAL HOME</p>	
<p>23. NAME OF FUNERAL HOME</p>		<p>24. NAME OF FUNERAL HOME</p>	
<p>25. NAME OF FUNERAL HOME</p>		<p>26. NAME OF FUNERAL HOME</p>	
<p>27. NAME OF FUNERAL HOME</p>		<p>28. NAME OF FUNERAL HOME</p>	
<p>29. NAME OF FUNERAL HOME</p>		<p>30. NAME OF FUNERAL HOME</p>	
<p>31. NAME OF FUNERAL HOME</p>		<p>32. NAME OF FUNERAL HOME</p>	
<p>33. NAME OF FUNERAL HOME</p>		<p>34. NAME OF FUNERAL HOME</p>	
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<p>41. NAME OF FUNERAL HOME</p>		<p>42. NAME OF FUNERAL HOME</p>	
<p>43. NAME OF FUNERAL HOME</p>		<p>44. NAME OF FUNERAL HOME</p>	
<p>45. NAME OF FUNERAL HOME</p>		<p>46. NAME OF FUNERAL HOME</p>	
<p>47. NAME OF FUNERAL HOME</p>		<p>48. NAME OF FUNERAL HOME</p>	
<p>49. NAME OF FUNERAL HOME</p>		<p>50. NAME OF FUNERAL HOME</p>	
<p>51. NAME OF FUNERAL HOME</p>		<p>52. NAME OF FUNERAL HOME</p>	
<p>53. NAME OF FUNERAL HOME</p>		<p>54. NAME OF FUNERAL HOME</p>	
<p>55. NAME OF FUNERAL HOME</p>		<p>56. NAME OF FUNERAL HOME</p>	
<p>57. NAME OF FUNERAL HOME</p>		<p>58. NAME OF FUNERAL HOME</p>	
<p>59. NAME OF FUNERAL HOME</p>		<p>60. NAME OF FUNERAL HOME</p>	
<p>61. NAME OF FUNERAL HOME</p>		<p>62. NAME OF FUNERAL HOME</p>	
<p>63. NAME OF FUNERAL HOME</p>		<p>64. NAME OF FUNERAL HOME</p>	
<p>65. NAME OF FUNERAL HOME</p>		<p>66. NAME OF FUNERAL HOME</p>	
<p>67. NAME OF FUNERAL HOME</p>		<p>68. NAME OF FUNERAL HOME</p>	
<p>69. NAME OF FUNERAL HOME</p>		<p>70. NAME OF FUNERAL HOME</p>	
<p>71. NAME OF FUNERAL HOME</p>		<p>72. NAME OF FUNERAL HOME</p>	
<p>73. NAME OF FUNERAL HOME</p>		<p>74. NAME OF FUNERAL HOME</p>	
<p>75. NAME OF FUNERAL HOME</p>		<p>76. NAME OF FUNERAL HOME</p>	
<p>77. NAME OF FUNERAL HOME</p>		<p>78. NAME OF FUNERAL HOME</p>	
<p>79. NAME OF FUNERAL HOME</p>		<p>80. NAME OF FUNERAL HOME</p>	
<p>81. NAME OF FUNERAL HOME</p>		<p>82. NAME OF FUNERAL HOME</p>	
<p>83. NAME OF FUNERAL HOME</p>		<p>84. NAME OF FUNERAL HOME</p>	
<p>85. NAME OF FUNERAL HOME</p>		<p>86. NAME OF FUNERAL HOME</p>	
<p>87. NAME OF FUNERAL HOME</p>		<p>88. NAME OF FUNERAL HOME</p>	
<p>89. NAME OF FUNERAL HOME</p>		<p>90. NAME OF FUNERAL HOME</p>	
<p>91. NAME OF FUNERAL HOME</p>		<p>92. NAME OF FUNERAL HOME</p>	
<p>93. NAME OF FUNERAL HOME</p>		<p>94. NAME OF FUNERAL HOME</p>	
<p>95. NAME OF FUNERAL HOME</p>		<p>96. NAME OF FUNERAL HOME</p>	
<p>97. NAME OF FUNERAL HOME</p>		<p>98. NAME OF FUNERAL HOME</p>	
<p>99. NAME OF FUNERAL HOME</p>		<p>100. NAME OF FUNERAL HOME</p>	

BUREAU V. S.

FEB 4 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1688

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. LENGTH OF STAY IN 1b <u>30 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DENTON - J - WERTZ</u>		4. DATE OF DEATH <u>Feb 8 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 17 - 1884</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hammer</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter A Wertz</u>		14. MOTHER'S MAIDEN NAME <u>Julia Koler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-10-7483A</u>	
17. INFORMANT <u>Harvey Wertz - Manchester Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 1947</u> , to <u>Feb 8 1957</u> , that I last saw the deceased alive on <u>Feb 8 1957</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Foard</u> M.D.		ADDRESS (Street, city or town, state) <u>Manchester, Md.</u> DATE SIGNED <u>2/9/57</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 11 - 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Buxton, E. W. B.</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw C Tipton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>Ms HPS. Denner</u> DATE <u>Feb 9 - 57</u>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH	
9. PLACE OF DEATH		10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF CORONER	
17. SIGNATURE OF MINISTER		18. SIGNATURE OF CHURCH		19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF BURIAL PLACE	
21. SIGNATURE OF INTERVIEWER		22. SIGNATURE OF INTERVIEWEE		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWEE	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWEE		27. SIGNATURE OF INTERVIEWER		28. SIGNATURE OF INTERVIEWEE	
29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWEE		31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWEE	
33. SIGNATURE OF INTERVIEWER		34. SIGNATURE OF INTERVIEWEE		35. SIGNATURE OF INTERVIEWER		36. SIGNATURE OF INTERVIEWEE	
37. SIGNATURE OF INTERVIEWER		38. SIGNATURE OF INTERVIEWEE		39. SIGNATURE OF INTERVIEWER		40. SIGNATURE OF INTERVIEWEE	
41. SIGNATURE OF INTERVIEWER		42. SIGNATURE OF INTERVIEWEE		43. SIGNATURE OF INTERVIEWER		44. SIGNATURE OF INTERVIEWEE	
45. SIGNATURE OF INTERVIEWER		46. SIGNATURE OF INTERVIEWEE		47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF INTERVIEWEE	
49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWEE		51. SIGNATURE OF INTERVIEWER		52. SIGNATURE OF INTERVIEWEE	
53. SIGNATURE OF INTERVIEWER		54. SIGNATURE OF INTERVIEWEE		55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF INTERVIEWEE	
57. SIGNATURE OF INTERVIEWER		58. SIGNATURE OF INTERVIEWEE		59. SIGNATURE OF INTERVIEWER		60. SIGNATURE OF INTERVIEWEE	
61. SIGNATURE OF INTERVIEWER		62. SIGNATURE OF INTERVIEWEE		63. SIGNATURE OF INTERVIEWER		64. SIGNATURE OF INTERVIEWEE	
65. SIGNATURE OF INTERVIEWER		66. SIGNATURE OF INTERVIEWEE		67. SIGNATURE OF INTERVIEWER		68. SIGNATURE OF INTERVIEWEE	
69. SIGNATURE OF INTERVIEWER		70. SIGNATURE OF INTERVIEWEE		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF INTERVIEWEE	
73. SIGNATURE OF INTERVIEWER		74. SIGNATURE OF INTERVIEWEE		75. SIGNATURE OF INTERVIEWER		76. SIGNATURE OF INTERVIEWEE	
77. SIGNATURE OF INTERVIEWER		78. SIGNATURE OF INTERVIEWEE		79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF INTERVIEWEE	
81. SIGNATURE OF INTERVIEWER		82. SIGNATURE OF INTERVIEWEE		83. SIGNATURE OF INTERVIEWER		84. SIGNATURE OF INTERVIEWEE	
85. SIGNATURE OF INTERVIEWER		86. SIGNATURE OF INTERVIEWEE		87. SIGNATURE OF INTERVIEWER		88. SIGNATURE OF INTERVIEWEE	
89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWEE		91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWEE	
93. SIGNATURE OF INTERVIEWER		94. SIGNATURE OF INTERVIEWEE		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWEE	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWEE		99. SIGNATURE OF INTERVIEWER		100. SIGNATURE OF INTERVIEWEE	

BUREAU V. S.

FEB 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01702

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY X X X X	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville #2		c. LENGTH OF STAY IN 1b 2½ Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Grand View Mansion, Sykesville #2, Md.		d. STREET ADDRESS 4431 Alan Drive	
3. NAME OF DECEASED (Type or print) First Middle Last Bertha Wienert		4. DATE OF DEATH Month Day Year February 27 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1874
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY X X X X	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Peter Goerke		14. MOTHER'S MAIDEN NAME Anna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. X X X X	
17. INFORMANT Address Gertrude Hinrichs 4431 Alan Drive, Baltimore			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease with 443X arteriosclerosis and chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 20 yrs(?) DUE TO advanced senile changes (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 August , 19 54 , to 27 February 19 57 , that I last saw the deceased alive on 27 February , 19 57 , and that death occurred at 5:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. H. Lawson, Jr., M.D.		ADDRESS (Street, city or town, state) Liberty Road at Eldersburg DATE SIGNED 2.27.57	
PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D.		Sykesville P.O., Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/1/57	22c. NAME OF CEMETERY OR CREMATORY Western	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witke ADDRESS 4101 Edmond		24a. REC'D BY REGISTRAR C. Harry Keen 24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

Reg. No. 104

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Manner of Death	
John Doe		45		Male		White		Jan 15, 1957		Home		Heart Disease		Natural	
Residence		Occupation		Education		Marital Status		Date of Birth		Date of Admission		Date of Discharge		Date of Death	
123 Main St.		Teacher		High School		Married		Jan 1, 1912		Jan 10, 1957		Jan 10, 1957		Jan 15, 1957	
City		County		State		Country		City		County		State		Country	
Baltimore		Anne Arundel		Maryland		U.S.A.		Baltimore		Anne Arundel		Maryland		U.S.A.	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Deceased		Signature of Family		Signature of Minister		Signature of Burial	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature	
Jan 15, 1957		Jan 15, 1957		Jan 15, 1957		Jan 15, 1957		Jan 15, 1957		Jan 15, 1957		Jan 15, 1957		Jan 15, 1957	

BUREAU V. S.

MAR 1 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore 23, Maryland 3 Vol-4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>7mo. 15days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRINGFIELD STATE HOSPITAL</u>				d. STREET ADDRESS <u>1400 W. Lexington St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Arthur</u> Last <u>YOUSE</u>				4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-22-79</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>		IF UNDER 24 HRS. Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>UNK</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>Christian Jacob Youse</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Ebert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-03-7642</u>		17. INFORMANT <u>Springfield State Hosp. records - Sykesville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>more than 6 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-13</u> , 19 <u>56</u> , to <u>2-28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-28</u> , 19 <u>57</u> , and that death occurred at <u>12:45PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>2-28-57</u>							
ACTUAL SIGNATURE <u>Martin Gross</u> M.D. <u>Springfield State Hospital</u>				PHYSICIAN'S NAME (Type) <u>Martin Gross, M. D.</u> <u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Paulson Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William (Park), Jr 1517 St Paul St. Balt.</u>				24a. REC'D BY REGISTRAR DATE <u>2/28/57</u>		24b. REGISTRAR'S SIGNATURE <u>C. H. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1950

PLACE OF BIRTH COUNTY		PLACE OF DEATH COUNTY	
DATE OF BIRTH MONTH DAY YEAR		DATE OF DEATH MONTH DAY YEAR	
SEX MALE FEMALE		RACE WHITE NEGRO OTHER	
OCCUPATION TRADE		CAUSE OF DEATH DISEASE INJURY	
PLACE OF DEATH HOME HOSPITAL OTHER		MANNER OF DEATH NATURAL ACCIDENTAL SUICIDE	
SIGNATURE OF DECEASED DATE		SIGNATURE OF WITNESS DATE	
SIGNATURE OF PHYSICIAN DATE		SIGNATURE OF CORONER DATE	
SIGNATURE OF REGISTRAR DATE		SIGNATURE OF CLERK DATE	

BUREAU V. 3

MAR 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>2 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>P.D. 4</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>PIERCE</u> First <u>H.</u> Middle <u>ZILE</u> Last				4. DATE OF DEATH <u>FEB.</u> Month <u>16</u> Day <u>1957</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 10-1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLANT FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>CHARLES ZILE</u>				14. MOTHER'S MAIDEN NAME <u>MARY HAHN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MARY G. ZILE WESTMINSTER, MD</u> Address <u>P.D. 4</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial degeneration</u> DUE TO <u>cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>renal disease</u> DUE TO (c) <u>2 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>emphysema</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec. 15, 1956</u> to <u>Feb. 16, 1957</u> that I last saw the deceased alive on <u>Feb. 9, 1957</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Reese Wilkens, M.D.</u>				DATE SIGNED <u>Feb 18/57</u>			
PHYSICIAN'S NAME (Type) <u>E. Reese Wilkens, Westminster</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-19-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>UNION TOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David G. Bankard</u> ADDRESS				24a. REC'D BY REGISTRAR <u>2-20-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

CERTIFICATE OF DEATH

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1092

1692
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FEB 25 1957
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